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	29C0001008	A. BUILDING _____ B. WING _____	05/06/2008

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AMERICAN SURGERY CENTER OF LAS	2575 LINDELL ROAD LAS VEGAS, NV 89102

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Q 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of a Medicare recertification survey conducted at your center on May 5 and 6, 2008. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. Fourteen patient records and 19 employee files were reviewed. The facility failed to maintain condition level compliance with the following Conditions of Coverage: 42 CFR 416.44 - Environment 42 CFR 416.46 - Nursing Services 42 CFR 416.48 - Pharmaceutical Services The following regulatory deficiencies were identified:	Q 000		
Q 010	416.44 ENVIRONMENT The ambulatory surgical center must have a safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of patients. This CONDITION is not met as evidenced by: The center failed to ensure the center has a safe and sanitary environment, properly constructed, equipped and maintained to protect the health and safety of patients (Q010); failed to ensure the center provided a sanitary environment for the provision of surgical services (Q011); and failed to ensure emergency medical equipment and	Q 010		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Q 010	Continued From page 1 supplies specified by the medical staff were in usable condition (Q016). The cumulative effect of these systemic practices resulted in the failure of the center to deliver statutory mandated patient care.	Q 010		
Q 011	416.44(a) PHYSICAL ENVIRONMENT The ambulatory surgical center must provide a functional and sanitary environment for the provision of surgical services. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the ambulatory surgery center (ASC) failed to ensure the center provided a sanitary environment for the provision of surgical services. Findings include: On the morning of 5/6/2008, a surgeon was observed in the pre-operative area. The surgeon administered an injection to Patient #14 who was being prepared for a corneal transplant. When the surgeon had finished administering the medication, the surgeon took the syringe with the needle exposed, pointed the needle upward and passed it to a nurse who was standing next to the surgeon assisting with procedures. The nurse then took the contaminated syringe and exposed needle and walked around the gurney where the patient was lying and took it over to the hazardous waste container located on the wall opposite of where the surgeon had handed off the syringe and needle. The nurse then placed the syringe and exposed needle in a hazardous waste container. There was no hazardous waste container located	Q 011		

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Q 011	Continued From page 2 near where the physician was standing so he could easily dispose of the contaminated waste. After the procedure had been completed, the nurse was interviewed and was asked if she thought this had been a safe procedure. The nurse stated no, but it was the way the physician always did it. The Director of Nursing (DON) was interviewed in the afternoon of 5/6/2008. When the DON was told what had occured, the DON indicated it would be very difficult to get the physician to dispose of the syringe and needle himself. On 5/6/08, the Policy and Procedure entitled, "C7.9, Disposal of Sharps and Needles" was reviewed. Under the area of "Procedure," one bulleted item read, "Sharps Containers will: Be easily accessible to employees and located where needles are commonly used." Observation 1. On 5/5/08 and 5/6/08 in the late morning, the "Clean" room was observed and the following observed: a. The space in the clean room for contaminated equipment coming from Operating Rooms 1 and 2 consisted of approximately 8" of counter space on the left side of the sink. This was the only designated space for dirty/contaminated equipment. b. All surgical instruments/equipment from Operating Rooms 1 and 2 was delivered to the "clean room" in a stainless steel "bucket." The buckets of dirty/contaminated equipment were placed on the small counter space to the left of	Q 011		

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Q 011	Continued From page 3 the sink for cleaning by the surgical technician in attendance. c. The "clean room" was accessed from 3 doors, a door from each operating room and a door which opened into the pre/post operative area. d. The "clean room" contained equipment to de-contaminate, clean, and sterilize equipment: a single sink with a water faucet, an ultrasonic cleaner, an ophthalmic "Quick Rinse AOI" flush machine, and a Steris AMSCO Renaissance Prevac Steam Sterilizer. The ultrasonic cleaner and the ophthalmic flush machine were placed on the countertop to the right of the sink. e. After surgical instruments/equipment were sterilized in the Steris sterilizer they were placed on a clean table in the sterilized "buckets" in the "clean room." The clean table was positioned directly across from the 3 scrub sinks in the "clean room." The clean table was placed in front of the door that opened into the pre/post operative area and just before Operating Room 2 door. 2. The "clean room" was busy with staff and equipment traffic from Operating Rooms 1 and 2. There was not sufficient space to place more than 1 bucket of dirty/contaminated equipment on the small counter space. 3. There was no clearly delineated separate space between the dirty/contaminated equipment, the clean table for the sterilized equipment, and the scrub sinks. All three areas were contained in a single, small room that did not allow for the separation between dirty and clean equipment.	Q 011		
Q 016	416.44(c) EMERGENCY EQUIPMENT	Q 016		

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Q 016	Continued From page 4 Emergency equipment available to the operating rooms must include at least the following: o Emergency call system. o Oxygen. o Mechanical ventilatory assistance equipment including airways, manual breathing bag, and ventilator. o Cardiac defibrillator. o Cardiac monitoring equipment. o Tracheostomy set. o Laryngoscopes and endotracheal tubes. o Suction equipment. o Emergency medical equipment and supplies specified by the medical staff. This STANDARD is not met as evidenced by: Based on observation and interview, the ambulatory surgery center (ASC) failed to ensure emergency medical equipment and supplies specified by the medical staff were in useable condition. Findings include: During the entrance conference on 5/5/08 at 9:10 A.M., the center indicated it performed both adult and pediatric cases. The crash cart, which was located just outside of operating room 2, was observed and the following items were observed: A pediatric catheter kit, which had a 'use by' date of 12/2007; An infant catheter kit, which had a 'use by' date of 01/2008; Two packages of "micro touch latex surgical gloves" that had expired on 05/2007 and 03/2008.	Q 016		

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Q 023	416.46 NURSING SERVICES The nursing services of the ambulatory surgical center must be directed and staffed to assure that the nursing needs of all patients are met. This CONDITION is not met as evidenced by: The center failed to ensure nursing services of the ambulatory surgery center (ASC) were directed and staffed to assure the nursing needs of all patients were met (Q023); and failed to ensure the patient care responsibilities were delineated for all nursing service personnel and provided in accordance with recognized standards of practice (Q024). The cumulative effect of these systemic practices resulted in the failure of the center to deliver statutory mandated patient care.	Q 023		
Q 024	416.46(a) ORGANIZATION AND STAFFING Patient care responsibilities must be delineated for all nursing service personnel. Nursing services must be provided in accordance with recognized standards of practice. There must be a registered nurse available for emergency treatment whenever there is a patient in the ambulatory surgical center. This STANDARD is not met as evidenced by: Based on observation, interview, record review and a review of policies and procedures, the ambulatory surgery center (ASC) failed to ensure nursing services were provided in accordance with recognized standards of practice. Findings include: 1. Patient #8 was admitted to the ASC on 5/6/2008 at 7:05 A.M., for cataract removal to the left eye. During the post-operative stay, which	Q 024		

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Q 024	Continued From page 6	Q 024		

began at 9:13 A.M., the patient's blood pressure was observed to be 197/95 per read-out on a blood pressure monitor. When interviewed, the patient stated she takes blood pressure medication one time every day in the evening. According to the Admit/Recovery Sheet, the patient's blood pressure upon admission at 8:25 A.M. was 152/81.

While continuing to observe Patient #8 and the post-operative nurse, it was observed the patient's physician came by and signed a piece of paper in the patient's chart. The physician then left. The post-operative nurse did not discuss the patient's blood pressure with the physician. The patient asked the nurse what her blood pressure was. The nurse responded by telling the patient it was 197/95. The nurse further stated to the patient that she should take her blood pressure medication when she got home.

Patient #8 was discharged at 9:40 A.M. The patient's blood pressure had not gone down from the 197/95. At the time of discharge, the post-operative nurse was asked what she thought about the patient being discharged with her blood pressure that high. The nurse stated the blood pressure had been even higher before the 197/95 reading, but it was coming down. The DON was notified about the blood pressure. The DON responded the patient would be told to go to one of the drug stores, get it re-checked and, if it were still high, to call the physician.

The ASC's policy and procedure entitled "C3.3, DISCHARGE CRITERIA," under "Procedure" read in part, "Before they qualify for discharge, all sedated/anesthesia patients must have a minimum of 2 sets of stable vital signs, an Aldrete

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Q 024	Continued From page 7 Score of at least 8, and at least 30 minutes elapsed since their last medication was administered. Any patient who does not receive sedation/local anesthesia may be discharged after one set of Post-Op vital signs." According to the "Operation" sheet, Patient #8 had received versed and fentanyl for sedation during the procedure. In the afternoon of 5/6/2008, during record review, the Admit/Recovery sheet was reviewed and it indicated only one blood pressure reading had been taken and the blood pressure was 195/97. The Pre-Anesthesia Record for Patient #8 dated 4-11-08 was reviewed. Under a checklist area entitled, "Do you or have you had....., 14. Heart attack (if yes, date); 15, Chest pain, Angina; 16, Irregular Pulse and 17, High blood pressure. All of these items were marked with an 'x' to indicate a yes. For #14, there was no date written in by the patient and under the 'no' column there was an 'NA,' which would indicate not applicable. The World Health Organization defines Normal blood pressure for adults as systolic blood pressure below 140 mmHg and diastolic blood pressure below 90 mmHg. 1. On 5/5/08 at 9:40 AM and on 5/6/08 at 8:25 AM, Employee #20 was observed performing the pre-admission duties for patients having surgery on that day. "Thirty three patients" were scheduled for surgery on 5/6/08. Employee #20's pre-admission duties included the following:	Q 024		

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Q 024	Continued From page 8 a. checking the patient in at the surgery center desk, b. walking with the patient into the pre-admission area, c. reviewing the patient's chart/paperwork, d. checking the patient's oral temperature with an electronic thermometer, e. placing an allergy identification armband on, f. having the patient sign the consent and other paperwork, g. placing a mark on the patient's forehead with a black Sharpie marker above the eye/eyebrow on the side of the eye to be operated on, h. placing a surgical hair cap and shoe covers on the patient, i. assisting the patient in putting a cloth gown over their clothes, and j. assisting the patient to the pre-operative area. 2. On both days and times of observation, Employee #20 was not seen washing her hands or using a hand sanitizer in between patients. On 5/6/08, Employee #20 was followed to the surgery center desk where patients check in, there was no hand sanitizer at the desk. Interview 1. On 5/6/08 at 2:05 PM, Employee #20 was interviewed regarding infection control measures used during patient contacts. Employee #20 indicated there was not any "kind of contact" with the patient and demonstrated the technique for checking oral temperatures. Employee #20 washed her hands whenever a patient would sneeze on her pen, after using the bathroom, before and after lunch, and after taking a smoking break. Employee #20 denied handwashing or using a hand sanitizer in between patient contact.	Q 024		

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Q 024	Continued From page 9 Employee #20 identified the sink in the nurses station in the pre/post-operative area as the location for her to wash her hands unless she was using the bathroom.	Q 024		
Q 029	416.48 PHARMACEUTICAL SERVICES The ambulatory surgical center must provide drugs and biologicals in a safe and effective manner, in accordance with accepted professional practice, and under the direction of an individual designated responsible for pharmaceutical services. This CONDITION is not met as evidenced by: The center failed to ensure drugs and biologicals were provided in a safe and effective manner, in accordance with accepted professional practice (Q029); and failed to ensure drugs were administered according to established policies and acceptable standards of practice (Q030). The cumulative effect of these systemic practices resulted in the failure of the center to deliver statutory mandated patient care.	Q 029		
Q 030	416.48(a) ADMINISTRATION OF DRUGS Drugs must be prepared and administered according to established policies and acceptable standards of practice. This STANDARD is not met as evidenced by: Based on observation, interview, a review of policies and procedures and Standards of Practice, the facility failed to ensure drugs were prepared and administered according to established policies and acceptable standards of practice. Findings include:	Q 030		

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Q 030	Continued From page 10 1. On 5/5/2008 at 9:10 A.M., upon entrance into the ASC, there was a notice taped to the top of the counter (front desk) where patients would sign in for their procedures. The notice, which was in large print, regarding the ASCs protocols read: 1) Does not reuse needles or syringes; 2) All instruments are cleaned and sterilized after each use; 3) Medications are single use for each patient. 2. On 5/6/08 from 11:10 A.M. to 12:15 P.M., observations were made in Operating Room 2 of Patient #14, who underwent a corneal transplant. During the surgery, the anesthesiologist who was assisting with sedation, administered medication through the patient's IV (intravenous) heparin lock (used for delivery of liquid mediation directly into the patient's vein/blood system); however, the anesthesiologist failed to clean the port with alcohol prior to injecting the medication. Prior to injecting the medication through the patient's heparin port (access port), the anesthesiologist was observed sitting on a stool and reading a National Geographic magazine; the anesthesiologist was not wearing gloves and did not wash his hands prior to injecting the medication. During an interview with the Director of Nursing (DON) on 5/6/08, in the afternoon, the DON stated the anesthesiologist should have wiped the heparin port with alcohol prior to administering any medication. 3. On 5/6/08, after the surgery for Patient #14 was completed, observations were made of one of the carts in Operating Room 2, which contained medications. The following items were	Q 030		

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Q 030	Continued From page 11 observed: A 20 milliliter vial of multi-dose labetalol, which had been opened for use. The vial was labeled as good for use from 3/27/08 through 4/25/08. A 10 milliliter vial of multi-dose neostigmine was labeled as good for use from 3/27/08 through 4/25/08. 4. During the morning on 5/6/08, observations of the medication storage area were made; a multi-dose vial of 50 milliliter of 2% lidocaine medication was found; the cap had been removed. The vial was labeled as good for use from 3/26/08 through 4/24/08. 5. On 5/6/08 at 8:20 A.M., a package containing a syringe of mitomycin (a hazardous agent which requires appropriate precautions for handling and disposal) was observed. The package was reviewed, and on the back of the package there was a note that had been written a black felt tip pen which instructed the next user to push hard on the syringe, as the syringe was not functioning properly. The package was shown to the Director of Nursing (DON), who immediately removed the package from the refrigerator and disposed of it with the ASCs hazardous waste. 6. On 5/6/08 at 11:00 A.M., observations were made of the refrigerator in the pre and post-operative area. A multi-dose vial of epinephrine (a medication used, in part, as an additive to local anesthetics to decrease system absorption of local anesthetics and increase duration of action) had the cap removed, indicating it had been used. The temperature of the refrigerator was 40 degrees Farenheit. The	Q 030		

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label on the vial indicated epinephrine should be stored at between 59 and 77 degrees Farenheit.

The DON, was interviewed at approximately 11:15 A.M. regarding the epinephrine then removed it from the refrigerator and discarded it.

7. During the observation of the refrigerator on 5/6/08 at 11:00 A.M., there was a multi-dose vial of succinylcholine that had expired on 5/1/08. This medication, too, was removed by the DON and discarded.

8. On 5/6/08 at 8:45 A.M. in operating room 1, the anesthesia cart was observed to have 11 vials of versed out on top of the cart, unlocked. There were no personnel in the operating room at the time. Versed (Midazolam) is a Class IV drug, a narcotic used for preoperative sedation.

During an interview on 5/6/08 at approximately 9:00 A.M., staff was asked about their procedures for logging in and out narcotic medications. Staff stated the versed was not logged out on the narcotic log. When asked how the narcotic count could be properly reconciled, staff replied if the anesthesiologist used some of the vials, they would be able to deduct that off of the total count at the end of the day - and if there was an confusion regarding dosages, they could go back through patient records and see what dosages each patient had gotten.

The policy and procedure entitled, "C6.3, Administration of Medication" reads, in part: All medications must be properly logged "in" and "out" of the appropriate medication log. The log includes the date, patient's name, doctor ordering, name and amount of medication, route

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Q 030	Continued From page 13	Q 030		

of administration, and a signature of a physician or nurse administering the substance. This was not done.

The American Society of Anesthesiologists position statement regarding, "Security of medications in the Operating Room" reads in the preamble, "A secure environment of care is needed for medication safety. Medication safety includes the security of oral, sublingual, parenteral, and inhaled drugs used for elective and emergency patient care." Also, under recommended policies - #2, "All Schedule 3 and 4 narcotic medications must be kept in locked enclosed areas when not under the direct control of an anesthesia professional." And, under #4, "Anesthesia carts and anesthesia machines may remain unlocked, and non-controlled medications (refers to medications that are are not Schedule 3 or 4 narcotics) may be left in or on top of unlocked anesthesia carts or anesthesia machines immediately prior to, during and immediately following surgical cases in an operating room, so long as there are authorized operating room personnel in the OR suite."

Observation

9. On 5/5/08 at 10:00 AM, Employee #8 was completing the insertion of an intravenous heparin lock on a pre-operative patient. After inserting and securing the heparin lock in the patient's left antecubital space, the employee was observed flushing the intravenous lock with a heparin-saline solution. The heparin used to flush the lock was drawn from a multidose vial, "Heparin Lock Flush USP," with a strength of 10 units per milliliter (mL), expiration date 5/1/08, Hospira Inc., Lake

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29C0001008	A. BUILDING _____ B. WING _____	05/06/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN SURGERY CENTER OF LAS	2575 LINDELL ROAD LAS VEGAS, NV 89102

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Q 030	Continued From page 14 Forest, Illinois, Lot #47 - 272 DK. The multidose vial of Heparin was also marked in black ink it had been opened on 5/1/08. Interview On 5/5/08 at 10:05 AM, the expiration date on the "Heparin Lock Flush" was verified with Employee #8.	Q 030		